

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-037417

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9812

FILED OCT 10 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

St. Louis

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION

4323 Fyler Ave.

Inside Limits
Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Mo.

b. COUNTY

admission)

c. CITY
OR TOWN

St. Louis

Inside Limits
Yes ☐ No ☐

d. STREET
ADDRESS

4323 Fyler Ave.

Reside on Farm
Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)

First

LOUIS(LUCIANO)

Middle

Last

CAROSELLO

4. DATE OF DEATH

Month

Day

Year

Oct. 1 1963

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH

12-13-1888 74

9. AGE (last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Lab. Technician-Laclede Christy Co.

10b. KIND OF BUSINESS OR INDUSTRY

Italy

Italy

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Antonio Carosello

13b. MOTHER'S MAIDEN NAME

Carmella Unknown

14. NAME OF HUSBAND OR WIFE

Joanne Carosello

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Joanne Carosello 4323 Fyler Ave.

18. CAUSE OF DEATH (Enter only one cause per line)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Carcinoma of Colon (Splenic flexure)

INTERVAL BETWEEN ONSET AND DEATH

1 yr

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

153.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour

a.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

7.3.63

to 10.1.63

and last saw her alive on 9.30.63

Death occurred at

6:30 P.

on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Type or title)

Sanley M. Thad MD

22b. ADDRESS

457 N. Kingshighway

22c. DATE SIGNED

10.2.63

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

23b. DATE

10-4-1963

23c. NAME OF CEMETERY OR CREMATORY

Resurrection Cemetery

23d. LOCATION (City, town, or county)

St. Louis Co. Mo.

24. FUNERAL DIRECTOR

ADDRESS

Kriegshauser 4228 S. Kingshighway

25. DATE RECD. BY LOCAL REG.

OCT 2 1963

26. REGISTRAR'S SIGNATURE

Paul Smith M.D.

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

DATE AMENDED

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Dr. Stanley M. Wald
457 N. Kingshighway

Fo. 7-5308

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed R. W. S. Townsend

Licensed Embalmer No. 4007

P. O. Address St. Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.